DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FOLLOWING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL HEALTHCARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: **02-28** | 2. STATE: **KS** |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>**December 31, 2002** | |

5. TYPE OF PLAN MATERIAL (Check *One*):

☐ NEW STATE PLAN ■ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.201, 42 CFR 442.10 | 7. FEDERAL BUDGET IMPACT<br>a. FFY 2003 $ 0<br>b. FFY 2004 $ 0 |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: See Attached | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: See Attached |

10. SUBJECT OF AMENDMENT:
Nursing Facility Methods and Standards for Establishing Payment Rates, Standards for Payment for Nursing Facilities.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED: Janet Schalansky is the Governor's Designee

| 12. SIGNATURE OF STATE AGENCY OFFICIAL: Janet Schalansky | 16. RETURN TO:<br>Janet Schalansky, Secretary<br>Social & Rehabilitation Services<br>Docking State Office Building<br>915 SW Harrison, Room 651S<br>Topeka, KS 66612-2210 |
|---|---|
| 13. TYPED NAME: Janet Schalansky | |
| 14. TITLE: Secretary | |
| 15. DATE SUBMITTED: | |

FOR REGIONAL OFFICE USE ONLY

| 17. DATE RECEIVED: 12/28/02 | 18. DATE APPROVED: 3/17/03 |
|---|---|

PLAN APPROVED – ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/31/02 | 20. SIGNATURE OF REGIONAL OFFICIAL: Barbara Smith |
|---|---|
| 21. TYPED NAME: ~~Thomas W. Lenz~~ Charlene Brown | 22. TITLE: ~~ARA for Medicaid & State Operations~~ Deputy Director CMSO |

23. REMARKS:

SPA CONTROL

Date Submitted:
Date Received:

FORM HCFA-179 (07-92)

**Instructions on Back**

30-10-17. Cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the "nursing facility financial and statistical report," form MS-2004, revised August 2002 and hereby adopted by reference, completed in accordance with the accompanying instructions. The MS-2004 cost report shall be submitted on diskette, using software designated by the agency for cost report periods ending on or after December 31, 1999.

(2) Each provider who has operated a facility for 12 or more months on December 31 shall file the nursing facility financial and statistical report on a calendar year basis.

(3) Each provider who has operated a facility on cost data from the previous provider or a projected cost report shall file an historical cost report.

(A) The historical cost report period shall begin according to either of the following schedules:

(i) On the first day of the month in which the nursing facility was certified if that date is on or before the 15th of the month; or

(ii) on the first day of the month following the date the nursing facility was certified if that date is on or after the 16th of the month.

(B) The historical cost report shall end on the last day of the 12-month period following the date specified in paragraph (a)

(3)(A) above, except under any of the following:

(i) The cost report shall end on December 31 when that date is not more than one month before or after the end of the 12-month period.

(ii) The cost report shall end on the provider's normal fiscal year-end used for the internal revenue service when that date is not more than one month before or after the end of the 12-month period and the criteria in K.A.R. 30-10-18 for filing the cost report ending on December 31 do not apply.

(iii) The cost report shall end on the last date of service if a provider change occurs before 11 months of operation and the interim rate was based on a projected cost report.

(C) The historical cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(D) The provider shall file a subsequent overlapping 12-month historical cost report for the calendar year ending December 31, if the first cost report does not end on that date.

(b) Projected cost data.

(1) Projected cost reports for providers.

(A) If a provider is required to submit a projected cost report under K.A.R. 30-10-18 (c) or (g), the provider's rate shall be based on a proposed budget with costs projected on a line item basis.

(B) The projected cost report for each provider who is required to file a projected cost report shall begin according to either of the following schedules:

(i) On the first day of the month in which the nursing facility was certified by the department of health and environment if that date is on or before the 15th of the month; or

(ii) on the first day of the following month if the facility is certified by the department of health and environment between the 16th and 31st of the month.

(C) The projected cost report shall end on the last day of the 12-month period following the date specified in paragraph (b)(1)(B) above, except under either of the following:

(i) The projected cost report shall end on December 31 when that date is not more than one month before or after the end of the 12-month period.

(ii) The projected cost report shall end on the provider's normal fiscal year-end used for the internal revenue service when that date is not more than one month before or after the end of the 12-month period and the criteria in K.A.R. 30-10-18 for filing the projected cost report ending on December 31 do not apply.

(D) The projected cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(E) The projected cost report shall be reviewed for

reasonableness and appropriateness by the agency. The projected cost report items that are determined to be unreasonable shall be disallowed before the projected rate is established.

(2) Projected cost reports for each provider with more than one facility.

(A) Each provider who is required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in state or out of state, shall allocate central office costs to each facility that is paid rates from the projected cost data. The provider shall allocate the central office cost at the end of the provider's fiscal year or the calendar year that ends during the projection period.

(B) The method of allocating central office costs to those facilities filing projected cost reports shall be consistent with the method used to allocate the costs to those facilities in the chain that are filing historical cost reports.

(c) Amended cost reports.

(1) Each provider shall submit an amended cost report revising cost report information previously submitted if an error or omission is identified that is material in amount and results in a change in the provider's rate of $.10 or more per resident day.

(2) An amended cost report shall not be allowed after 13 months have passed since the last day of the year covered by the

report.

(d) Due dates of cost reports.

(1) Each calendar year cost report shall be received not later than the close of business on the last working day of February following the year covered by the report.

(2) Each historical cost report covering the first year of operation shall be received by the agency not later than the close of business on the last working day of the second month following the close of the period covered by the report.

(3) Each cost report approved for a filing extension in accordance with subsection (e) shall be received not later than the close of business on the last working day of the month approved for the extension request.

(e) Extension of time for submitting a cost report.

(1) A one-month extension of the due date for the filing of a cost report may be granted by the agency when the cause for delay is beyond the control of the provider. Delays beyond the control of the provider that may be considered by the agency in granting an extension shall include the following:

(A) Disasters that significantly impair the routine operations of the facility or business;

(B) destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonably foreseeable; and

(C) computer viruses that impair the accurate completion of cost report information.

(2) The provider shall make the request in writing. The request shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

(3) A written request for a second one-month extension may be granted by the Kansas medical assistance program director if the cause for further delay is beyond the control of the provider. The request shall be received by the agency on or before the due date of the cost report, or the request shall not be approved.

(f) Penalty for late filing. Each provider filing a cost report after the due date shall be subject to the following penalties:

(1) If the complete cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.

(2) Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program.

(g) Balance sheet requirement. Each provider shall file a balance sheet prepared in accordance with cost report instructions

as part of the cost report forms for each provider.

(h) Working trial balance requirement. Each provider shall submit a working trial balance with the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account, and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance and shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be attached.

(i) An allocation of expenditures between the hospital and the long-term care unit facility shall be submitted through a step-down process prescribed in the cost report instructions.

(j) This regulation shall be effective on and after December 31, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002; amended Dec. 31, 2002.)

EXCEL VERSION

MS-2004

State of Kansas
Department of Social and Rehabilitation Services/
Department on Aging

Rev. 8/02

NURSING FACILITY FINANCIAL AND STATISTICAL REPORT

| | | | | |
|---|---|---|---|---|
| SEND TO: KANSAS DEPARTMENT ON AGING | AGENCY USE ONLY | | | |
| New England Building | (1,2) | | RETRO ADJUSTMENT | |
| 503 S. Kansas Avenue | (3,4) | | FULL | PARTIAL |
| TOPEKA, KANSAS 66603-3404 | (5,6) | | | |

INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

| | |
|---|---|
| PROVIDER ID NUMBER (NEED 10 DIGITS)<br>0 | 11. EMPLOYERS' FEDERAL ID NUMBER<br>0 |
| 12. PROVIDER NAME (The person or business organization responsible for meeting requirements, providing services and receiving payments.)<br>0 | 13. FACILITY NAME<br>0 |
| 14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP)<br>0 0 0 0 | |

| | | | |
|---|---|---|---|
| 16. ADMINISTRATOR'S NAME<br>0 | 17a. PHONE NUMBER<br>0<br>17b. FAX NUMBER<br>0 | 18. EMAIL ADDRESS 0<br>19. REPORT PERIOD<br>01/00/00 TO 01/00/00 | 20. FISCAL YEAR END<br>01/00/00 |

| | | |
|---|---|---|
| CHECK ONLY ONE | 21. ___ EXISTING FACILITY (HISTORICAL)<br>23. ___ NEW FACILITY (PROJECTED)<br>25. ___ HISTORICAL F/Y OVERLAPS PROJECTION/1ST YEAR PERIOD | 22. ___ NEW PROVIDER (PROJECTED)<br>24. ___ HISTORICAL R/Y SAME AS PROJECTED/1ST YEAR PERIOD |
| CHECK ONLY ONE | 26. ___ SOLE PROPRIETORSHIP 27. ___ PARTNERSHIP 28. ___ CORP - PROFIT<br>29. ___ CORP. - NON PROFIT 30. ___ CITY OWNED 31. ___ COUNTY OWNED<br>32. ___ OTHER - GOVERNMENT OWNED 33. ___ OTHER (SPECIFY) | |

| NURSING FACILITY BEDS | BED INCREASE OR DEC. | DATE OF CHANGE | BED COUNT | BED DAYS AT THIS BED COUNT |
|---|---|---|---|---|
| 43. NURSING FACILITY OR NF-MENTAL HEALTH BEDS AT THE BEG. OF THE PERIOD | | | 0 | 0 |
| 43a. | 0 | 0 | 0 | 0 |
| 43b. | 0 | 0 | 0 | 0 |
| 43c. | 0 | 0 | 0 | 0 |
| 43d. | 0 | 0 | 0 | 0 |
| 45. TOTAL NF OR NF-MH LICENSED BEDS AT THE END OF THE PERIOD | | | | 0 |
| 46. TOTAL BED DAYS AVAILABLE (TOTAL OF BED DAYS AT THIS COUNT COLUMN FROM LINES 43 THROUGH 43d) | | | | 0 |
| 48. TOTAL NURSING FACILITY /NFMH RESIDENT DAYS (ALL RESIDENTS FROM AU-3902 DISKETTE) | | | (4) | 0 |
| 48a. TOTAL MEDICAID DAYS | | | (5) | 0 |
| 48b. TOTAL MEDICARE DAYS | | | | 0 |

| OTHER FACILITY BEDS | BEGINNING OF PERIOD | BED INCREASE OR DEC. | DATE OF CHANGE | END OF PERIOD |
|---|---|---|---|---|
| 49. ASSISTED LIVING/RES. CARE | 0 | 0 | 01/00/00 | 0 |
| 50. UNLICENSED BEDS | 0 | 0 | 01/00/00 | 0 |
| 51. OTHER RESIDENTIAL DAYS WITH SHARED NURSING FACILITY COSTS (ALL RESIDENTS FROM AU-3903 DISKETTE) | | | | 0 |

| | | | |
|---|---|---|---|
| 52. DOES THE FACILITY HAVE MEDICARE CERTIFIED BEDS? | ☐ YES | ☐ NO | IF YES, COMPLETE 48b |
| 53. IS THIS FACILITY (please check one): | ☐ HOSPITAL BASED LTCU | ☐ FREE-STANDING NF | |

This form Supersedes Form MS-2004, Rev. 12/01

EXCEL VERSION

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER
0

SCHEDULE A — EXPENSE STATEMENT

| OPERATING COST CENTER | LN# | TOTAL ANNUAL HOURS PAID (1) | PER BOOKS OR FEDERAL TAX RETURN (2) | PROVIDER ADJUSTMENTS (3) | RESIDENT RELATED EXPENSES (4) | (AGENCY USE) STATE ADJUSTMENTS (5) | (AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6) |
|---|---|---|---|---|---|---|---|
| SALARY - ADMINISTRATOR | 101 | 0 | $0 | $0 | $0 | | $0 |
| SALARY - CO ADMINISTRATOR | 102 | 0 | $0 | $0 | $0 | | $0 |
| OTHER ADMINISTRATIVE SALARIES | 103 | 0 | $0 | $0 | $0 | | $0 |
| PLANT OPERATING SALARIES | 104 | 0 | $0 | $0 | $0 | | $0 |
| EMPLOYEE BENEFITS | 119 | | $0 | $0 | $0 | | $0 |
| OWNER/RELATED PARTY ADMIN COMPENSATION - SCHEDULE C | 121 | | $0 | $0 | $0 | | $0 |
| OWNER/RELATED PARTY PLNT OP COMPENSATION - SCHEDULE C | 122 | | $0 | $0 | $0 | | $0 |
| OWNER/RELATED PARTY EMPLOYEE BENEFITS | 125 | | $0 | $0 | $0 | | $0 |
| CONTRACTED LABOR | 130 | | $0 | $0 | $0 | | $0 |
| MANAGEMENT CONSULTANT FEES | 131 | | $0 | $0 | $0 | | $0 |

Page 2 of 16

EXCEL VERSION MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER 0

SCHEDULE A EXPENSE STATEMENT

| OPERATING COST CENTER | LN# | TOTAL ANNUAL HOURS PAID (1) | PER BOOKS OR FEDERAL TAX RETURN (2) | PROVIDER ADJUSTMENTS (3) | RESIDENT RELATED EXPENSES (4) | (AGENCY USE) STATE ADJUSTMENTS (5) | (AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6) |
|---|---|---|---|---|---|---|---|
| ALLOCATION OF CENTRAL OFFICE COSTS (SEE INSTRUCTIONS) | 151 | | $0 | $0 | $0 | | $0 |
| OFFICE SUPPLIES & PRINTING | 152 | | $0 | $0 | $0 | | $0 |
| PHONE & OTHER COMMUNICATION | 153 | | $0 | $0 | $0 | | $0 |
| TRAVEL | 154 | | $0 | $0 | $0 | | $0 |
| ADVERTISING AND RECRUITMENT | 155 | | $0 | $0 | $0 | | $0 |
| LICENSES & DUES | 156 | | $0 | $0 | $0 | | $0 |
| ACCOUNTING & DATA PROCESSING | 157 | | $0 | $0 | $0 | | $0 |
| LIABILITY INSURANCE | 158 | | $0 | $0 | $0 | | $0 |
| OTHER INSURANCE (EXCEPT LIFE) | 159 | | $0 | $0 | $0 | | $0 |
| INTEREST (EXCEPT RE LOANS) | 160 | | $0 | $0 | $0 | | $0 |
| LEGAL | 161 | | $0 | $0 | $0 | | $0 |
| CRIMINAL BACKGROUND CHECK | 162 | | $0 | $0 | $0 | | $0 |
| REAL & PERSONAL PROPERTY TAX | 163 | | $0 | $0 | $0 | | $0 |
| MAINTENANCE & REPAIRS | 164 | | $0 | $0 | $0 | | $0 |
| OPERATING SUPPLIES | 165 | | $0 | $0 | $0 | | $0 |
| SMALL EQUIPMENT (SEE INSTRUCTIONS) | 166 | | $0 | $0 | $0 | | $0 |
| OTHER (PLEASE SPECIFY) | 181 | | $0 | $0 | $0 | | $0 |
| **TOTAL OPERATING COST CENTER** | 190 | 0 | $0 | $0 | $0 | $0 | $0 |

Page 3 of 16

EXCEL VERSION

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER 0

**SCHEDULE A** **EXPENSE STATEMENT**

| INDIRECT HEALTH CARE COST CENTER | LN# | TOTAL ANNUAL HOURS PAID (1) | PER BOOKS OR FEDERAL TAX RETURN (2) | PROVIDER ADJUSTMENTS (3) | RESIDENT RELATED EXPENSES (4) | (AGENCY USE) STATE ADJUSTMENTS (5) | (AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6) |
|---|---|---|---|---|---|---|---|
| DIETARY SALARIES | 201 | 0 | $0 | $0 | $0 | | $0 |
| HOUSEKEEPING SALARIES | 202 | 0 | $0 | $0 | $0 | | $0 |
| LAUNDRY SALARIES | 203 | 0 | $0 | $0 | $0 | | $0 |
| MEDICAL RECORDS SALARIES | 204 | 0 | $0 | $0 | $0 | | $0 |
| OCCUPATIONAL THERAPIST SALARIES | 205 | 0 | $0 | $0 | $0 | | $0 |
| PHYSICAL THERAPIST SALARIES | 206 | 0 | $0 | $0 | $0 | | $0 |
| PSYCH. THERAPIST SALARIES | 207 | 0 | $0 | $0 | $0 | | $0 |
| RECREATIONAL THERAPIST SALARIES | 208 | 0 | $0 | $0 | $0 | | $0 |
| RESPIRATORY THERAPIST SALARIES | 209 | 0 | $0 | $0 | $0 | | $0 |
| SPEECH THERAPIST SALARIES | 210 | 0 | $0 | $0 | $0 | | $0 |
| RESIDENT ACTIVITIES SALARIES | 211 | 0 | $0 | $0 | $0 | | $0 |
| SOCIAL WORKER SALARIES | 212 | 0 | $0 | $0 | $0 | | $0 |
| OTHER IHC SALARIES (SPECIFY) | 213 | 0 | $0 | $0 | $0 | | $0 |
| EMPLOYEE BENEFITS | 219 | | | | | | |
| OWNER/RELATED PARTY COMPENSATION - SCHEDULE C | 221 | | $0 | $0 | $0 | | $0 |
| OWNER/RELATED PARTY EMPLOYEE BENEFITS | 225 | | $0 | $0 | $0 | | $0 |
| CONTRACTED LABOR | 230 | | $0 | $0 | $0 | | $0 |
| DIETARY CONSULTANT | 231 | | $0 | $0 | $0 | | $0 |
| MEDICAL RECORDS - CONSULTANT | 232 | | $0 | $0 | $0 | | $0 |
| OCCUPATIONAL THERAPY - CONSULTANT | 233 | | $0 | $0 | $0 | | $0 |
| PHARMACIST - CONSULTANT | 234 | | $0 | $0 | $0 | | $0 |
| PHYSICAL THERAPY - CONSULTANT | 235 | | $0 | $0 | $0 | | $0 |
| RESPIRATORY - CONSULTANT | 236 | | $0 | $0 | $0 | | $0 |
| SPEECH THERAPY - CONSULTANT | 237 | | $0 | $0 | $0 | | $0 |
| OTHER CONSULTANT (SPECIFY) | 238 | | $0 | $0 | $0 | | $0 |

EXCEL VERSION MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER 0

**SCHEDULE A EXPENSE STATEMENT**

| INDIRECT HEALTH CARE COST CENTER | LN# | TOTAL ANNUAL HOURS PAID (1) | PER BOOKS OR FEDERAL TAX RETURN (2) | PROVIDER ADJUSTMENTS (3) | RESIDENT RELATED EXPENSES (4) | (AGENCY USE) STATE ADJUSTMENTS (5) | (AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6) |
|---|---|---|---|---|---|---|---|
| UTILITIES | 251 | | $0 | $0 | $0 | | $0 |
| FOOD | 252 | | $0 | $0 | $0 | | $0 |
| DIETARY SUPPLIES | 253 | | $0 | $0 | $0 | | $0 |
| LINEN & BEDDING MATERIAL | 254 | | $0 | $0 | $0 | | $0 |
| LAUNDRY & LINEN SUPPLIES | 255 | | $0 | $0 | $0 | | $0 |
| HOUSEKEEPING SUPPLIES | 256 | | $0 | $0 | $0 | | $0 |
| RESIDENT ACTIVITY SUPPLIES | 257 | | $0 | $0 | $0 | | $0 |
| RESIDENT TRANSPORTATION | 258 | | $0 | $0 | $0 | | $0 |
| BARBER AND BEAUTY | 259 | | $0 | $0 | $0 | | $0 |
| NURSE AIDE TRAINING | 260 | | $0 | $0 | $0 | | $0 |
| OTHER HEALTH CARE TRAINING | 261 | | $0 | $0 | $0 | | $0 |
| OTHER (PLEASE SPECIFY) | 281 | | $0 | $0 | $0 | | $0 |
| **TOTAL INDIRECT HEALTH CARE COST CENTER** | 290 | 0 | $0 | $0 | $0 | | $0 |

Page 5 of 16

EXCEL VERSION

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER 0

**SCHEDULE A** **EXPENSE STATEMENT**

| DIRECT HEALTH CARE COST CENTER | LN# | TOTAL ANNUAL HOURS PAID (1) | PER BOOKS OR FEDERAL TAX RETURN (2) | PROVIDER ADJUSTMENTS (3) | RESIDENT RELATED EXPENSES (4) | (AGENCY USE) STATE ADJUSTMENTS (5) | (AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6) |
|---|---|---|---|---|---|---|---|
| LICENSED MENTAL HEALTH TECH SALARIES | 301 | 0 | $0 | $0 | $0 | | $0 |
| LICENSED PRACTICAL NURSE SALARIES | 302 | 0 | $0 | $0 | $0 | | $0 |
| MEDICATION AIDE SALARIES | 303 | 0 | $0 | $0 | $0 | | $0 |
| NURSE AIDE SALARIES | 304 | 0 | $0 | $0 | $0 | | $0 |
| REGISTERED NURSE (RN) SALARIES | 305 | 0 | $0 | $0 | $0 | | $0 |
| RESTORATIVE/REHAB AIDE SALARIES | 306 | 0 | $0 | $0 | $0 | | $0 |
| EMPLOYEE BENEFITS | 319 | | $0 | $0 | $0 | | $0 |
| OWNER/RELATED PARTY COMPENSATION - SCHEDULE C | 321 | | $0 | $0 | $0 | | $0 |
| OWNER/RELATED PARTY EMPLOYEE BENEFITS | 325 | | $0 | $0 | $0 | | $0 |
| CONTRACTED NURSING LABOR | 330 | | $0 | $0 | $0 | | $0 |
| NURSING CONSULTANTS | 331 | | $0 | $0 | $0 | | $0 |
| NURSING SUPPLIES | 351 | | $0 | $0 | $0 | | $0 |
| **TOTAL DIRECT HEALTH CARE COST CENTER** | 390 | 0 | $0 | $0 | $0 | | $0 |
| **TOTAL RATE FORMULA COSTS** | 399 | 0 | $0 | $0 | $0 | | $0 |

| OWNERSHIP COST CENTER | | | | | | | |
|---|---|---|---|---|---|---|---|
| INTEREST - REAL ESTATE | 401 | | $0 | $0 | $0 | | $0 |
| RENT/LEASE EXPENSE | 402 | | $0 | $0 | $0 | | $0 |
| AMORTIZED LEASEHOLD IMPROVEMENT | 403 | | $0 | $0 | $0 | | $0 |
| DEPRECIATION EXPENSE | 404 | | $0 | $0 | $0 | | $0 |
| **TOTAL OWNERSHIP COST CENTER** | 490 | | $0 | $0 | $0 | $0 | $0 |

Page 6 of 16

EXCEL VERSION

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER 0

SCHEDULE A — EXPENSE STATEMENT

| NON-REIMBURSABLE & NON-RESIDENT RELATED EXPENSE ITEMS | LN# | TOTAL ANNUAL HOURS PAID (1) | PER BOOKS OR FEDERAL TAX RETURN (2) | PROVIDER ADJUSTMENTS (3) | RESIDENT RELATED EXPENSES (4) | (AGENCY USE) STATE ADJUSTMENTS (5) | (AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6) |
|---|---|---|---|---|---|---|---|
| BAD DEBTS | 501 | | $0 | $0 | $0 | | |
| PROVISION FOR INCOME TAXES | 502 | | $0 | $0 | $0 | | |
| NONWORKING OWNERS/OFFICERS - SCHEDULE C | 503 | | $0 | $0 | $0 | | |
| DONATIONS | 504 | | $0 | $0 | $0 | | |
| FUND RAISING/PROMO & NON-REIMBURSABLE ADVERTISING | 505 | | $0 | $0 | $0 | | |
| LIFE INSURANCE - OWNERS/OFFICERS | 506 | | $0 | $0 | $0 | | |
| OXYGEN CONCENTRATORS & CYLINDERS | 507 | | $0 | $0 | $0 | | |
| DRUGS - PHARMACEUTICALS | 508 | | $0 | $0 | $0 | | |
| VENDING MACHINES | 509 | | $0 | $0 | $0 | | |
| BOARD OF DIRECTORS EXPENSE | 510 | | $0 | $0 | $0 | | |
| RESIDENT PURCHASES | 511 | | $0 | $0 | $0 | | |
| OTHER (PLEASE SPECIFY) | 512 | | $0 | $0 | $0 | | |
| OTHER (PLEASE SPECIFY) | 513 | | $0 | $0 | $0 | | |
| OTHER (PLEASE SPECIFY) | 514 | | $0 | $0 | $0 | | |
| **TOTAL NON-REIMBURSABLE** | 590 | | $0 | $0 | $0 | | |
| **TOTAL** | 599 | 0 | $0 | $0 | $0 | $0 | $0 |

ATTACH A DETAILED DEPRECIATION SCHEDULE AND THE DETAILED WORKING TRIAL BALANCE USED TO PREPARE THIS COST REPORT

Page 7 of 16